MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH 7618

PLACE OF DEATH

nty Shelby

nship Salt River Registration District No. 830 File No. 10

ge. ~~Hunnewell~~ Mo Primary Registration District No. 6091 Registered No.

(NO. ____ St.; ____ Ward) [If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME Martha Margaret Adams

PERSONAL AND STATISTICAL PARTICULARS

X	COLOR OR RACE	SINGLE MARRIED WIDOWED OR DIVORCED (Write the word)
~~male~~	White	Widow

TE OF BIRTH: June (Month) 28th (Day), 1830 (Year)

E: 92 yrs. 7 mos. 11 ds. IF LESS than 1 day, ____ hrs. or ____ min.?

CUPATION (Trade, profession, or ticular kind of work): Housework

General nature of industry, ness, or establishment in ch employed (or employer):

THPLACE (y or town, e or foreign country): Pleasureville, Kentucky

NAME OF FATHER: James Pannel Sparks

BIRTHPLACE OF FATHER (City or town, State or foreign country): Pleasureville, Kentucky

MAIDEN NAME OF MOTHER: Sally Threlkeld

BIRTHPLACE OF MOTHER (City or town, State or foreign country): Pleasureville, Kentucky

E ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

formant) Jane Adams

(ADDRESS) 316 So Lawn Av, Kansas City Mo

ed Feb. 10, 1923 Madge Gooch REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH February (Month) 9 (Day), 1923 (Year)

I HEREBY CERTIFY, that I attended deceased from Jan. 27, 1923 to Feb. 9, 1923, that I last saw her alive on Feb. 9, 1923, and that death occurred, on the date stated above, at 5.30 ~~A~~ P m.

The CAUSE OF DEATH* was as follows:

1a. Bronchitis

1b.

1c.

(Duration) ____ yrs. ____ mos. 14 ds.

Contributory (SECONDARY) Senility

(Duration) ____ yrs. ____ mos. ____ ds.

(Signed) James H Headd M. D.

Feb 9. 1923 (Address) Hunnewell, Mo

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ____ yrs. ____ mos. ____ ds. In the State ____ yrs. ____ mos. ____ ds.

Where was disease contracted if not at place of death?

Former or usual residence

PLACE OF BURIAL OR REMOVAL: IOOF Cem DATE OF BURIAL: Feb 10, 1923

UNDERTAKER: E Hayes Shelbina ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

V. S. No. 2.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

V. S. No. 2.

MARGIN RESERVED FOR BINDING

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N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

PLACE OF DEATH

County.....

Township ..... Registration District No. ..... File No. .....
or
Village..... Primary Registration District No. ..... Registered No. .....
or
City ..... (NO. .... St.; ..... Ward)

[If death occurr hospital or inst give its NAME of street and num

MISSOURI STATE BOARD OF HEA

BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

FULL NAME.....

PERSONAL AND STATISTICAL PARTICULARS

SEX	COLOR OR RACE	SINGLE MARRIED WIDOWED OR DIVORCED (*Write* the word)

DATE OF BIRTH

..... (Month) ....., 1..... (Day) ..... (Year)

AGE

..... yrs. ..... mos. ..... ds.

If LESS than 1 day, ... hrs. or ..... min.?

OCCUPATION
(a) Trade, profession, or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer) .....

BIRTHPLACE
(City or town, State or foreign country)

PARENTS

NAME OF FATHER

BIRTHPLACE OF FATHER
(City or town, State or foreign country)

MAIDEN NAME OF MOTHER

BIRTHPLACE OF MOTHER
(City or town, State or foreign country)

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant).....

(ADDRESS).....

Filed ....., 191.....

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH

....., 1
(Month) (Day) (

I HEREBY CERTIFY, that I attended deceased

....., 191....., to....., 19

that I last saw h..... alive on....., 19

and that death occurred, on the date stated above, at.....

The CAUSE OF DEATH* was as follows:

.....

.....

.....

.....(Duration).....yrs.....mos.....

Contributory.....
(SECONDARY)

.....(Duration).....yrs.....mos.....

(Signed)..... M

....., 191..... (Address).....

*State the Disease Causing Death, or, in deaths from Violent Causes, (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS INSTITUTIONS, TRANSIENTS RECENT RESIDENTS)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....

Where was disease contracted if not at place of death? .....

Former or usual residence.....

PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL ....., 19
UNDERTAKER	ADDRESS